Compliance Audit

of the

Commonwealth of Pennsylvania
Department of Public Welfare
Medicaid Eligibility

Luzerne County Assistance Office
Wilkes Barre District

Audit Period
June 1, 2006 to April 4, 2008

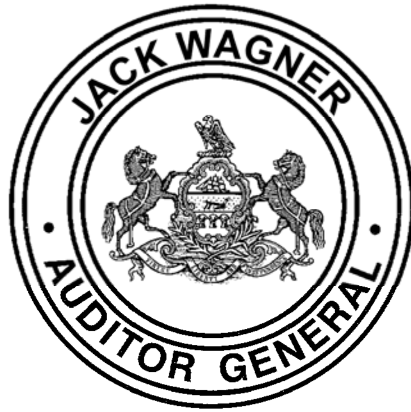
Compliance Audit

of the

Commonwealth of Pennsylvania
Department of Public Welfare
Medicaid Eligibility

Luzerne County Assistance Office
Wilkes Barre District

Audit Period
June 1, 2006 to April 4, 2008


JACK WAGNER
AUDITOR GENERAL

CONTENTS

Page

REPORT OF INDEPENDENT AUDITORS ON COMPLIANCE 1

BACKGROUND INFORMATION 4

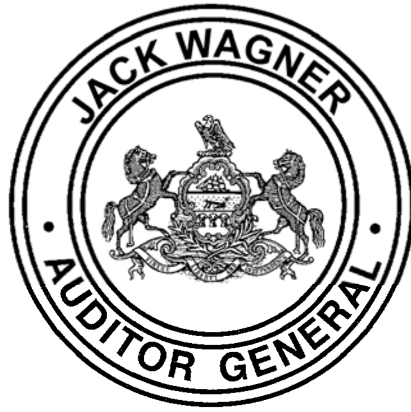
OBJECTIVES, SCOPE, AND METHODOLOGY..8

FINDINGS AND RECOMMENDATIONS

Finding No. 1 - Failure To Make Proper Medicaid Eligibility Determinations 10

Finding No. 2 - Failure To Obtain And/Or Properly Record All Third Party Liability On The Client Information System...18

AUDIT REPORT DISTRIBUTION LIST 21


JACK WAGNER
AUDITOR GENERAL

Report of Independent Auditors on Compliance

The Honorable Edward G. Rendell
Governor
Commonwealth Of Pennsylvania
Harrisburg, Pennsylvania 17120

Dear Governor Rendell:

We have conducted a compliance audit of the Luzerne County Assistance Office (CAO), Wilkes Barre District, pursuant to the authority of Title 55, Chapter 109 of the Pennsylvania Code and P.S. §402 and §403 of the Fiscal Code. The audit period was June 1, 2006 through April 4, 2008. The objectives of our audit were:

1) To determine whether the CAO made proper eligibility determinations for recipients of Medicaid based on Department of Public Welfare (DPW) policies and procedures, while evaluating the CAO's implementation of the Medicaid Eligibility Determination Automation (MEDA) system; and

2) To determine whether the CAO obtained and properly recorded all third-party liability in the Client Information System.

When recipients are not eligible for Medicaid, the cost to Pennsylvania taxpayers of the resulting improper payments could be significant. For individuals in a managed care organization (MCO), a set monthly capitation fee is paid to the MCO even if the recipient did not receive services during the period of ineligibility. For individuals not in an MCO, the amount of improper payments depends on the types of services, such as prescriptions, hospitalization, dental services, and other medical services received by individuals during periods of ineligibility. It should be noted that payments made on behalf of ineligible recipients cannot be recouped by the Commonwealth from the MCO or from individual providers.

A burden of improper Medicaid payments to taxpayers also occurs when CAOs do not obtain and record sources of existing Third Party Liability (TPL) insurance into the system. Medicaid

law states that Medicaid funds should not be paid for services covered by TPL insurance - in other words, Medicaid funds should only be paid as a last resort when other sources are not available. When CAOs do not obtain and record sources of existing TPL insurance into the system, DPW's Medicaid payment system is unaware of the TPL insurance and pays for services or pays capitation fees that should not be paid with Medicaid funds.

Our audit resulted in the following findings.

Finding No. 1 - Failure To Make Proper Medicaid Eligibility Determinations

Finding No. 2 - Failure To Obtain And/Or Properly Record All Third Party Liability On The Client Information System

During the November 19, 2008 exit conference, we reviewed these findings and recommendations with the Luzerne CAO, Wilkes Barre District, representatives. We have included the CAO and DPW comments, where applicable, in this report.

Sincerely,

JACK WAGNER
Auditor General

February 2, 2010

Commonwealth of Pennsylvania
Department of Public Welfare
Luzerne County Assistance Office
Wilkes Barre District

BACKGROUND INFORMATION

Background Information

The Department of Public Welfare (DPW) is responsible for the administration of public assistance benefits to needy recipients in Pennsylvania. Benefits include cash assistance, food stamps and Medicaid. Cash assistance is grant money which falls into two categories: Temporary Assistance to Needy Families (TANF), a federally-funded program which provides money to families with dependent children who are needy because financial support is not available from one or both parents, and General Assistance (GA), a state-funded program which provides money primarily to single individuals and childless couples who do not have enough income to meet their basic needs and who do not qualify for TANF. The Food Stamp program is designed to offer assistance to low-income households in order to raise their level of nutrition. It is federally funded and operated jointly by the U.S. Department of Agriculture, Food and Nutrition Service, and DPW. Medicaid is the federal health care program for families and individuals with low income and resources. It is funded jointly by both the state and the federal government. DPW administers the program while the federal Centers for Medicare and Medicaid establishes requirements for service delivery, quality and eligibility standards.

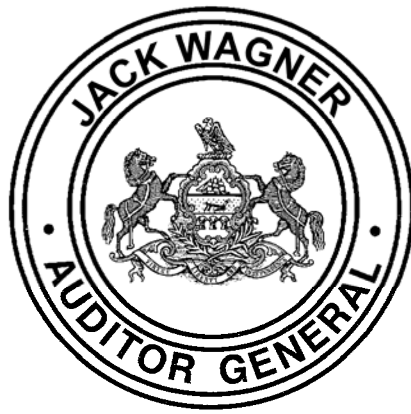
Eligibility determinations are based on federal and state regulations specifying which individuals qualify for a program and the amounts for which they qualify. The Code of Federal Regulations (CFR) contains the applicable federal regulations. The Pennsylvania Code, which includes DPW's Cash Assistance Handbook, Medicaid Eligibility Handbook and Supplemental Handbook contain the applicable state regulations.

Once an applicant is determined eligible for benefits, relevant information about the recipient is recorded and maintained in DPW's Client Information System (CIS), where benefit information is maintained based on eligibility status and category of aid. The CAO performs a "renewal" or annual review, to determine continued eligibility for benefits.

CAO personnel utilize DPW's Income Eligibility Verification System (IEVS) to compare income and resource information with income and resource information obtained from outside sources. IEVS is updated on a regular basis with information from several sources including wage information from the Department of Labor and Industry, benefit information from the SSA, and tax and unearned income information from the Internal Revenue Service. CAO caseworkers are required to review this information at the time of application, when the recipient submits their semi-annual reporting (SAR) form and at the annual renewal. Caseworkers receive an alert when they are required to review new wage information received between the application date, the SAR and the annual

renewal. However, IEVS only sends caseworkers an alert when there is wage information from a new or additional employer. IEVS does not provide caseworkers an alert when there is an increase in wages from ongoing employment even though the wage increase could affect a recipient's eligibility. Consequently, information that could affect a recipient's continued eligibility for benefits is not received until the recipient's SAR or annual review.

DPW recently implemented the Medicaid Eligibility Determination Automation (MEDA) system which was designed to automatically determine the level of Medicaid coverage based on demographic, resource and income information entered by the caseworker. Prior to this implementation, the caseworker made manual calculations to determine Medicaid eligibility.


JACK WAGNER
AUDITOR GENERAL

Commonwealth of Pennsylvania
Department of Public Welfare
Luzerne County Assistance Office
Wilkes Barre District

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives, Scope, And Methodology

To achieve our audit objectives regarding eligibility we obtained a quarterly data file from the Department of Public Welfare of all recipients determined by the CAOs to be eligible for Medicaid benefits as of September 30, 2007. We selected a random sample of 141 cases from the 14,114 cases related to the Luzerne CAO, Wilkes Barre District, represented in the data file. Our audit period was June 1, 2006 to April 4, 2008, however in cases where we determined an ineligible individual was receiving Medicaid benefits, we expanded our test work through the last date of his or her ineligibility.

For each case selected in our sample, we tested certain aspects of eligibility and evaluated the CAO's examination and recording of third party liability to determine compliance with DPW regulations, governing laws, and administrative policies. We also tested cases that changed category when they were converted to MEDA to evaluate whether MEDA made the proper category determination.

The criteria we used to test cases in our sample included the Medicaid Eligibility Handbook, the Income Eligibility Verification System (IEVS) Manual, and the Client Information System Manual.

It is DPW's position that the Department of the Auditor General is not authorized to have access to all information that contains wage and unearned income from the IRS. This scope limitation prevents us from confirming that all resources were included in calculating recipients' eligibility for benefits.

Commonwealth of Pennsylvania
Department of Public Welfare
Luzerne County Assistance Office
Wilkes Barre District

FINDINGS AND RECOMMENDATIONS

Findings and Recommendations

Our audit testing included 141 out of 14,114 Medicaid cases. Cases where a significant number of deficiencies occurred are discussed in the following findings:

Finding No. 1 - <u>Failure To Make Proper Medicaid Eligibility Determinations</u>

During our audit we found that CAO personnel improperly determined recipient eligibility in 66 of the 141, or 47% of the cases we tested. Recipients in these cases were either over the income limit or did not meet other conditions of eligibility such as age limitation, citizenship, disability or family relationship requirements. In 42 of these cases, recipients were not eligible for Medicaid benefits, and in 12 additional cases the recipients had periods of ineligibility and periods where they were placed in the incorrect category of aid. In 53 of these 54 cases, benefits were paid for recipients while they were ineligible. As a result, improper payments of $83,859 were issued to both managed care organizations and individual providers on behalf of recipients[1], as shown in Table 1, beginning on page 11 of this report. Specifically, $62,432 was issued to managed care organizations in the form of capitation payments and $21,427 was issued to providers in the form of medical claims paid. Payments made on behalf of ineligible recipients cannot be recouped by the Commonwealth from MCOs or from individual providers. In addition, we found no evidence that recoveries for Medicaid are pursued by DPW or referred for collection to the Office of Inspector General. Consequently, it is important for DPW to monitor recipients' eligibility, immediately identify ineligible recipients, and stop payment of benefits on their behalf.

In 12 of 66 cases, recipients were placed in the incorrect category of aid although they had no periods of ineligibility. Failure to place recipients in the proper category of aid could result in recipients receiving services for which they are not entitled, or being denied services for which they are entitled. Because we do not have access to all wage and unearned income information as noted in our scope limitation on page 8 of this report, we were not able to ascertain whether CAO personnel utilized all available wage and unearned income information to determine Medicaid eligibility. As a result, additional improper payments could have been made and not discovered during our audit.

The Medicaid Eligibility Handbook provides criteria to assist the CAO in making proper eligibility determinations.

---

[1] In a fee-for-service environment providers are paid directly for services they provide to recipients. In a managed care environment, contracted managed care organizations are paid a set monthly capitation fee for all members of their organization whether or not members (recipients) received services. The managed care organization is then responsible to pay providers of services.

These improper determinations occurred because:

- The CAO management did not monitor to ensure that recipients met the age limitation requirements, were disabled and that they met the family relationship requirement.
- The CAO management did not monitor to ensure that citizenship and identity of recipients were verified during the application and renewal process.
- The CAO management did not monitor to ensure that income amounts were properly entered on the Client Information System.
- The CAO management did not monitor to ensure that income from IEVS history was properly reconciled with reported income at application and renewals.
- The CAO management did not monitor to ensure that income from IEVS alerts was properly reconciled with reported income.
- The CAO management did not monitor to ensure that the annual renewals and semi-annual reviews took place on the date they should have been done.
- DPW's policy does not require a review of all changes to income, including income from ongoing employment, when the information becomes available on IEVS. Instead, DPW's policy requires information regarding ongoing employment be reviewed only during a recipient's annual renewal or semi- annual review.

Table 1

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
1.	MA-3	07/20/07	02/28/08	$1,849.11
2.	MA-7	04/12/07	02/24/08	2,189.85
3.	MA-11	08/01/06	11/30/06	441.59
		04/01/07	08/20/07	402.01
4.	MA-12	10/18/06	03/04/08	2,092.34

Table 1 (continued)

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
5.	MA-14	11/14/06	01/29/08	$4,700.46
6.	MA-16	08/05/06	11/28/07	327.03
7.	MA-18	10/26/06	03/22/08	1,528.89
8.	MA-19	08/02/06	08/09/07	191.19
9.	MA-20	01/23/07	03/20/08	2,500.50
10.	MA-21	02/01/07	09/11/07	2,526.01
11.	MA-23	06/20/07	07/05/07	331.66
12.	MA-28	06/07/07	03/17/08	8,285.06
13.	MA-29	01/01/08	02/21/08	691.76
14.	MA-35	06/01/06	07/19/07	2,870.70
15.	MA-45	06/01/06	09/24/06	1,655.87
16.	MA-47	07/01/07	12/31/07	6,423.91
17.	MA-54	06/01/06	10/16/06	1,996.54
		02/11/07	07/03/07	259.13
18.	MA-56	06/30/07	04/14/08	1,685.73
		06/01/06	07/02/07	1,200.35
19.	MA-58	05/01/07	04/27/08	1,066.71
20.	MA-60	03/01/08	03/03/08	89.20
21.	MA-64	02/29/07	03/19/08	1,165.04
22.	MA-67	02/02/07	03/23/08	3,495.12
23.	MA-74	01/01/07	03/31/07	561.43
24.	MA-81	11/11/06	07/11/07	3,769.21
25.	MA-83	11/06/06	03/30/08	4,784.62
26.	MA-85	04/01/07	01/24/08	644.83
27.	MA-86	09/23/06	04/01/07	1,183.65
28.	MA-89	12/01/07	03/19/08	351.87
29.	MA-96	10/16/07	04/30/08	2,049.72
30.	MA-98	10/01/07	11/14/07	176.71
31.	MA-99	07/01/07	07/31/07	57.26
		09/01/07	11/30/07	168.10
32.	MA-100	10/08/07	04/13/08	2,255.20
33.	MA-102	01/20/07	02/24/08	1,756.83

Table 1 (continued)

	Case Number	Ineligibility Period		Benefits Paid
		From	To	
34.	MA-104	08/01/06	09/03/06	$95.25
35.	MA-105	10/01/06	12/31/06	117.38
		11/01/06	05/01/08	1,693.96
		11/01/06	08/23/07	3,605.09
36.	MA-111	11/01/06	06/15/07	996.25
37.	MA-114	05/29/07	10/08/07	1,443.00
38.	MA-116	04/01/06	04/30/06	164.86
		06/01/06	10/31/06	567.40
		12/01/06	01/24/07	96.66
39.	MA-117	02/01/08	04/22/08	93.45
40.	MA-120	07/03/07	04/23/08	3,766.86
41.	MA-122	06/01/07	04/30/08	319.45
42.	MA-127	05/01/07	04/09/08	207.79
43.	MA-129	11/01/07	12/31/07	273.53
44.	MA-130	02/01/07	10/14/07	260.25
45.	MA-132	09/01/07	04/23/08	445.05
46.	MA-133	03/01/08	03/26/08	89.20
47.	MA-135	03/01/07	03/31/07	69.02
48.	MA-138	09/01/07	12/24/07	353.56
49.	MA-139	06/28/07	01/31/08	622.50
50.	MA-145	02/01/08	04/20/08	259.41
51.	MA-146	07/17/07	09/11/07	179.96
52.	MA-147	12/31/07	01/16/08	32.04
53.	MA-148	03/28/08	04/16/08	381.55
	Total			**$83,858.66**

Recommendations

To ensure that proper eligibility determinations are made, we recommend that CAO Management:

- Ensure that personnel are adequately trained to understand the eligibility requirements pertaining to age, disability and family relationship criteria for Medicaid categories.

- Ensure that personnel are adequately trained to verify citizenship and identity during the application and renewal process.

- Ensure that personnel are trained to accurately enter income information into the Client Information System.

- Improve monitoring to ensure that caseworkers properly reconcile reported income with IEVS history at application and renewals.

- Improve monitoring to ensure that caseworkers properly reconcile reported income with IEVS alerts.

- Improve monitoring to ensure caseworkers perform annual renewals and semi-annual reviews in a timely manner.

We also recommend that DPW:

- Follow up with the Office of Inspector General to see if overpayments made on behalf of recipients can be recouped.

- Change its policy to require a review of all changes in income including income from ongoing employment when it becomes available.

Management Response

In a November 16, 2009 letter to this Department, DPW management provided the following response:

> The Department has reviewed the 66 cases that the Auditor General's office cited for having improper determinations. The finding states in 42 of these cases, recipients were not eligible for Medicaid benefits and in 12 additional cases the recipients had periods of ineligibility and periods where they were placed in the incorrect category of aid. In 53 of these 54 cases, benefits were paid for recipients while they were ineligible. In 12 of the 66 cases, recipients were placed in the incorrect category of aid although they had no periods of ineligibility.

The Department disagrees with the following cases that were cited as deficiencies in the audit:

Case MA-3: The auditors cited a deficiency for lack of verification of citizenship for Lines 04, 06, and 07. The CAO does not agree with the time period for the deficiency. The client had an appeal and benefits were continued pending the outcome of the appeal. The CAO proposed a closing date effective 7/15/2007 for failure to provide the requested verification related to income.

As part of the hearing adjudication the client was sent a new renewal form that the CAO received on 10/11/2007. At that point the CAO should have verified citizenship. The CAO failed to do so; therefore the CAO should have closed the case. The correct time period would be 10/12/2007 to 2/28/2008 instead of the timeframe cited in the draft report as 7/20/2007-10/11/2007.

Case MA-18: The CAO failed to obtain verification of citizenship and identity for Line 07, . . . at the 10/25/06 renewal. The period and amount of the overpayment was determined by the auditors. PVM13211322 instructs the CAO to provide automatic coverage for newborns, and to pursue citizenship and identity information at the first subsequent renewal following the addition of the newborn. The first renewal following the one year period of automatic eligibility for Line 07 occurred on 10/25/07. The revised audit changed the "from date" from 10/26/07 to 10/26/06.

Cases MA-56, 132 & 146: The auditor's determination of a client's ineligibility for a specific MA category is used as the basis for a determination of a period of ineligibility and resultant overpayment. However, as noted in SH910.473 [55 PA Code § 255.84(d)(3)], "Claims are determined based on services paid through the Health Care Benefit Package the individual would have been assigned to if the facts of the overpayment were known." In the instances cited, the auditor did not consider offsetting benefits and services the individual would have received if the facts of the overpayment were known.

To address the finding, CAO Managers will re-emphasize to caseworkers the need to follow the established eligibility determination procedures and

will take a more active role in case review through mandated automated reviews which are tracked by computer software. In addition, the Department is reviewing its eligibility determination procedures, including those regarding changes in income, to determine if its policies and procedures can be improved. Any overpayments made on behalf of recipients due to improper Medicaid eligibility determinations will be referred to the Office of Inspector General for possible recovery of funds.

Auditors Conclusion

The audit objective is to determine whether the CAO made proper eligibility determinations for Medicaid recipients. The notices of deficiencies submitted to the CAO during the field work reflected the eligibility criteria that were not met and the periods of ineligibility.

With regard to MA-3 and MA-18, we disagree that periods of ineligibility are incorrect. During our audit we determine that the period of ineligibility begins with the date the recipient was no longer meeting the eligibility requirement for the Medicaid category. DPW is minimizing the actual dollars associated with our periods of ineligibility because they are incorrectly applying Medicaid policy. For instance, in the MA-3 case, DPW shortened the period of ineligibility to only include timeframes beginning with when the recipient’s appeal was decided. Also, in the MA-18 case, DPW shortened the period of ineligibility because they incorrectly determined that they did not have to review the citizenship and identity requirements at the renewal. The amount and periods of ineligibility in these cases should remain as written.

In addition, in cases MA-56, MA-132 and MA-146 we disagree that recipients would have been eligible in another Medicaid category. In these cases, recipients failed to meet the financial or non financial eligibility requirements for any other Medicaid category. We tested all cases to determine if recipients met another category of Medicaid and reported these cases in the second paragraph of Finding 1 of this report. Subsequent to our field work completion date, the CAO has provided no additional supporting documentation to prove otherwise.

With regard to calculating “overpayment”, DPW considers the period of ineligibility to start at the point when the ineligibility is discovered, not when the recipient actually became ineligible. Keeping this in mind, the dollar amount of the “overpayment” is not a true picture of the amount of taxpayer dollars spent for benefits paid on behalf of

ineligible recipients as noted in Table 1, beginning on page 11 of this report. More importantly, payments made on behalf of ineligible recipients cannot be recouped by the Commonwealth from MCOs or from individual providers. DPW should ensure that CAO personnel are adequately trained to understand the eligibility requirements. Therefore, our finding remains as written.

Finally, we acknowledge DPWs efforts to re-emphasize to the CAOs the need to follow the established eligibility determination procedures and are encouraged that DPW is reviewing its eligibility determination procedures to establish if its policies and procedures can be improved. However, it is clear that current procedures have not been effective in verifying whether or not a recipient is eligible to receive benefits. Without better monitoring procedures in place, these deficiencies will continue to occur.

Finding No. 2 - <u>Failure To Obtain And/Or Properly Record All Third Party Liability On The Client Information System</u>

During our audit we determined that in 46 of the cases we tested, or 33% of our sample, the CAO failed to obtain and/or properly record all third party liability into the Client Information System. Specifically, in 13 of these cases, the recipient's case record included documentation of auto insurance which was not recorded in the Client Information System. In 28 of these cases, an auto was listed as a resource; however documentation of auto insurance was neither contained in the case record, nor listed on the Client Information System. In 4 of these cases, the recipient's case record included documentation of both medical and auto insurance which was not included in the Client Information System. We also determined that in 1 of the cases, the CAO failed to obtain documentation of health insurance from recipients who had health coverage under another plan.

DPW's claims processing system makes payments to providers based on information found on the Client Information System. If no other insurance information is recorded, it is possible that medical claims will be paid with Medicaid funds, including medical claims and the cost of hospitalization resulting from auto accidents.

The Medicaid Eligibility Handbook, Chapter 338.2, and CFR 433.138 and 433.139 provide criteria to assist the CAO in properly identifying and recording all third party resources.

These deficiencies occurred because:

- The CAO management did not monitor to ensure that third party insurance information was entered into the Client Information System even though this documentation was contained in the case record.

- The CAO management did not monitor to ensure that third party insurance information was obtained during the application and renewal process.

- The CAO management did not monitor to ensure that auto insurance information was obtained and entered into the Client Information System, even though an auto was listed as a resource.

Failure to obtain and/or enter all third party liability resources into the Client Information System increases the likelihood that medical claims will be paid by Medicaid, which should be the payor of last resort.

Recommendations

We recommend that CAO Management ensure that caseworkers request all third party resources, including auto insurance, during the application and renewal processes and enter this information into the Client Information System. Also, DPW should revise current policy to require recipients to show evidence of auto insurance when an auto is listed as a resource.

Management Response

In a November 16, 2009 letter to this Department, DPW management provided the following response:

> The audit recommends that CAO management ensure that caseworkers request all third party resources, including auto insurance, during application and renewal processes and enter this information in the CIS. Also, DPW should revise current policy to require recipients to show evidence of auto insurance when an auto is listed as a resource.
>
> DPW has reviewed the recommendations that CAO management ensure that caseworkers request all third party resources, including auto insurance, during the application and renewal processes and enter this information into a Client Information System (CIS). Also, the recommendation states that DPW should revise current policy to require recipients to show evidence of auto insurance when an auto is listed as a resource.
>
> The DPW reviewed the process of collecting auto insurance information at the time of application for benefits, and the issues that arise with the past process. A decision was made that it would be more prudent and cost effective to handle these cases through the TPL recovery process. The State Plan approved by Centers for Medicare and Medicaid Services (CMS) flags the trauma diagnosis codes and follows the approved process

to recover the funds. This process recovers funds not just from the owner of a vehicle but from any participant in CIS that is in an accident or has an injury which is coded as trauma or casualty claims. Identifying auto insurance only for the owner of an auto during the application and/or renewal process would obviously exclude any individual who does not own an auto; however, they could nevertheless suffer trauma as a result of injuries sustained in an automobile accident in which they were involved in a non-owned automobile (e.g. as a passenger).

The Department through TPL seeks recovery, unless it has been determined that the recovery will not be cost effective. The Department accumulates claims for six months in an attempt to reach the threshold amounts. The threshold for casualty claims is $250 and $50 for health insurance claims, although these threshold amounts can be waived when it is deemed to be economically and administratively feasible to collect less than the stated amounts.

Auditors Conclusion

The Medicaid Eligibility Handbook, which is part of our audit criteria, was revised to reflect DPW's change in policy after our audit period. In addition, even though the criteria no longer requires CAO caseworkers to enter available auto TPL into the Client Information System, doing so decreases the likelihood that medical claims resulting from auto accidents would automatically be paid with Medicaid funds, which should be the payor of last resort. Therefore, our finding remains as written and we continue to recommend that CAO caseworkers request and enter all third party resources, including auto insurance, into the Client Information System.

Audit Report Distribution List

This report was originally distributed to the following:

<u>Commonwealth of Pennsylvania</u>

The Honorable Edward G. Rendell
Governor

Harriet Dichter
Acting Secretary
Department of Public Welfare

The Honorable Mary A. Soderberg
Secretary
Office of the Budget

The Honorable Donald L. Patterson
Inspector General
Office of Inspector General

The Honorable Patricia Vance
Chair
Public Health and Welfare Committee
Senate of Pennsylvania

The Honorable Vincent Hughes
Democratic Chair
Public Health and Welfare Committee
Senate of Pennsylvania

The Honorable Frank Oliver
Chair
Health and Human Services Committee
Pennsylvania House of Representatives

The Honorable Robert McCord
State Treasurer

The Honorable Matthew Baker
Republican Chair
Health and Human Services Committee
Pennsylvania House of Representatives

Tina Long, Director
Division of Financial Policy & Operations
Bureau of Financial Operations
Office of Administration
Department of Public Welfare

Linda T. Blanchette, Deputy Secretary
Office of Income Maintenance
Department of Public Welfare

Joanne Glover, Director
Bureau of Operations
Office of Income Maintenance
Department of Public Welfare

John Kaschak, Director
Bureau of Audits
Office of the Budget

<u>County Assistance Office</u>

William Schabener, Executive Director
Luzerne County Assistance Office

Chairperson
Luzerne County Board of Assistance

George Missett, District Manager
Luzerne County Assistance Office
Wilkes Barre District

This report is a matter of public record. Copies of this report may be obtained from the Pennsylvania Department of the Auditor General, Office of Communications, 318 Finance Building, Harrisburg, PA 17120. If you have any questions regarding this report or any other matter, you may contact the Department by accessing our website at www.auditorgen.state.pa.us.